COMMITTEE ON MENTAL HEALTH AND SUBSTANCE ABUSE
MENTAL HEALTH PARITY OVERSIGHT HEARING

TESTIMONY OF
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COMMISSIONER
DEPARTMENT OF MENTAL HEALTH
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Chairwoman Balser, Chairman Tolman, members of the Committee, thank you for holding this important hearing on mental health parity. My name is Elizabeth Childs. As Commissioner of Mental Health, and as a practicing psychiatrist, I have seen directly the tremendous benefit that the mental health parity law has brought to citizens of the Commonwealth.

On May 4, 2000 the General Court struck a blow against the stigma of mental illness by enacting Chapter 80 of the Acts of 2000 – the Massachusetts Mental Health Parity law. For the first time, health insurers regulated by state law were required to provide non-discriminatory coverage for a wide range of biologically based mental illnesses. Among the list of specific covered diagnoses were some of the most disabling conditions that afflict our citizens, including schizophrenia, major depressive disorder and bi-polar disorder.

Before discussing the impact of Parity, it is important to remember why parity is so important.

- Mental illness affects 1 in 4 families in the United States. Your family, my family, each and every one of us is affected – we have mental illness in our own families, or we know families touched by this illness.
- We now know, and are learning more everyday, that mental health and physical health are inextricably bound together. We cannot have good physical health without good mental health.
- Parity is not only good social policy, it is good business policy. A World Health Organization and Harvard University study reveals that mental illness, including suicide, accounts for over 15 percent of the burden of disease in established market economies, such as the United States. This is more than the disease burden caused by all cancers.
- The same study found that the total economic burden of mental illness was $83.1 billion in 2000. Of this total, $26.1 billion (31%) were direct treatment costs, $5.4 billion (7%) were suicide-related costs, and $51.5 billion (62%) were workplace costs. And experts agree that the disability burden of psychiatric illness is greatly underestimated.
- Treatment for mental illness works. In fact, treatment success rates for major depression and bipolar disorder range from 65% to 80%. While the success rate for treatment of heart disease ranges from 41 to 52%, and when we treat mental

illness, we reduce other medical costs – one recent study showed that people with chronic medical conditions lowered their medical costs between 18 and 31 percent after receiving psychiatric or psychological services and treatment.

What does parity mean in Massachusetts? As you know, our parity law covers specific "biologically based" illnesses. It prohibits imposition of annual or lifetime dollar or unit of service limitations for these disorders if the limitation is less than any imposed on coverage for physical conditions. If a plan does not limit coverage for diabetes or high blood pressure, it cannot limit coverage for these mental illnesses. Recognizing the importance of treating mental illnesses early, the parity law provides broader coverage for children and adolescents, including non-biologically based mental, behavioral or emotional disturbances which substantially interfere with or substantially limits the child or adolescent's functioning and social interactions.

The primary goal of parity is to increase access to treatment for individuals with mental illness. The key is getting in the door. If we can provide access to treatment, more individuals will take advantage of it. The more people we can treat – and treat successfully – the greater will be the savings in reduced worker absenteeism and productivity. As we demonstrate the success of mental health treatment, we can reduce the stigma of the illness, and can encourage more individuals to seek treatment, further enhancing the productivity of our workforce. It is a classic win-win situation.

I have seen this in my own practice. I know first hand of dozens of adults and children with serious mental illnesses – chronic depression, bi-polar illness – who have taken advantage of treatment made available to them as a result of parity; who are highly functioning, productive members of society; who, without treatment would likely be disabled, unable to work, dependant.

As important as the Massachusetts parity law is, we must recognize that the statute only covers insurance payers that are regulated by state law, plans that are primarily purchased by smaller companies. Insurance plans that are governed by federal law – particularly self-insured plans – are not covered by our parity statute. That means that Massachusetts workers who work in larger firms rely on federal law for parity coverage.

As we examine the impact of parity in Massachusetts, we should recognize that our statute is not the only model for parity.

Some states with similar biologically based statutes have broader lists of covered diagnoses, and some even include substance abuse, which as you know, our statute does not. A few states (Connecticut and Vermont) have so-called "terms and conditions" statutes which mandate coverage for recognized mental illnesses on the same terms and conditions as are applied to physical illnesses. The U.S. Substance Abuse and Mental Health Services Administration – SAMHSA – published a study of the Vermont statute, which was enacted in 1998. I have attached a copy of the executive summary to my written testimony. The full 119-page report is available on the internet on the SAMSHA website (http://store.mentalhealth.org/publications/allpubs/sma03-3822/default.asp).

Among the most significant findings of the SAMSHA study were that, while utilization of outpatient mental health services across the two major private insurers in Vermont increased from 6 to 8 percent after parity, overall costs of mental health services were minimally impacted. The study further found that consumers paid a smaller share of the total amount spent on mental health and substance abuse services following the implementation of parity. For example, the share paid out-of-pocket by one payer's members fell from 27 to 16 percent of total mental health and substance abuse spending.

This report's results suggest that this parity law did not hurt business, or significantly increase the burden on Vermont's health care system.

Our biggest challenge as we further examine parity is to decide whether, and how, to expand parity coverage. There are bills before the Legislature to add substance abuse and eating disorders to the list. We at the Department of Mental Health have received inquiries about post traumatic stress disorder, as well as eating disorders and other illnesses. As we learn more and more about the biological causes of mental illness, the scope of potential covered conditions is broad. The minimum statutory criteria for adding diagnoses are that they be "biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of Insurance." But, in addition to biological basis and scientific recognition, factors such as cost and availability of effective treatment need to be considered. We must consider together whether there are to be additions or changes to parity in Massachusetts. Health insurance is increasingly becoming unaffordable for many of our small businesses and residents and we must be thoughtful in our assessment of any new mandates.

Thank you for the opportunity to address this committee. I would be pleased to provide you with further information or to answer any questions you may have.